PCN95

A SYSTEMATIC REVIEW OF QUALITY OF LIFE INSTRUMENTS IN LONG TERM BREAST CANCER SURVIVORS

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OBJECTIVES: Breast cancer is the most common cancer in women, representing 16% of all female cancers. According to American Cancer Society (ACS), long-term cancer survival is defined as more than five years of survivorship since diagnosis, with approximately 2.5 million breast cancer survivors (BCS) in 2006. The long-term effects from breast cancer and its treatment have been shown to have positive and negative effects on both recovery and survivors' quality of life (QoL). The purpose of the study is to identify QoL instruments that have been validated in long-term BCS and to review the studies that have used the QoL instruments in this population. **METHODS:** A systematic literature search was conducted from January 1990 to October 2010 using electronic databases. Instruments validated in BCS were included in the review. In addition, QoL studies in long-term BCS using the validated instruments were reviewed. The search was limited to studies using English language. Studies of BCS of less than five years after initial diagnosis, any clinical or review studies were excluded. **RESULTS:** A total of 12 QoL instruments were identified (10 disease-specific, 2 condition-specific). According to the QoL framework proposed by Ferrell and colleagues, three identified instruments (Quality of Life-Cancer Survivors, Quality of Life in Adult Cancer Survivors Scale (QLACS), and Quality of Life Index-Cancer Version) evaluated all four domains (physical, psychological, social, and spiritual) of QoL. A review of the psychometric evaluation showed that QLACS has acceptable reliability, validity, and responsiveness in long-term BCS. The review also yielded 19 studies that used the QoL instruments. The study results indicated that age-groups, ethnicity, and type of treatment influenced different aspects of QoL. **CONCLUSIONS:** There is a significant impact of breast cancer on long-term BCS's QoL. The review can help researchers and clinicians select the most appropriate instruments to assess the changes in QoL in BCS.

PCN96

CANCER PATIENT PREFERENCES AND WILLINGNESS TO PAY FOR PREVENTING CHEMOTHERAPY INDUCED NAUSEA AND VOMITING IN THE UNITED STATES

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OBJECTIVES: This study assessed willingness to pay (WTP) to avoid chemotherapy induced nausea and vomiting (CINV) among 303 cancer patients. It also assessed differences in WTP by patient-level characteristics. **METHODS:** WTP was assessed using results from a choice-based conjoint survey. Patients viewed 25 scenarios each involving 2 descriptions of CINV and indicated which they preferred. Each scenario represented a combination of levels from 8 attributes (e.g., chance of nausea). Preference for levels within attributes and WTP were assessed using a probit model. Interaction terms were added to determine if strength of preference and WTP differed by demographics, disease characteristics, treatment history, and history of CINV. **RESULTS:** Patients were 79% Caucasian and 16% African American with a mean age of 59.35 years (range=26-86). Forty percent had breast cancer, 35% lung cancer, and 25% colorectal cancer. Sixty-eight percent were on HEC/MEC, 22% had been on HEC/MEC in the last 6 months, and 10% were chemotherapy naïve. Patients were willing to pay to avoid more than 30% chance of nausea (WTP to avoid 50%: $42.61, p = 0.0004; WTP to avoid 70%: $49.57, p = 0.0002), more than 1 day of nausea (2-5 days: $62.80, p <0.0001; 5+ days: $107.50, p <0.0001), nausea that impaired functioning (some activities: $103.87, p <.0001; self-care: $116.32, p <0.0001), vomiting more than 1-2 times/day (3-5 times/day: $45.52, p <0.0001; 5+ times/day: $52.10, p <0.0001), vomiting longer than a half-day (1 day: $20.12, p = 0.0162; 2-5 days: $133.05, p <.0001), and dehydration not treatable at home (clinic visit: $61.26, p <0.0001; hospital visit: $109.47, p <0.0001). WTP varied by income, primary diagnosis, disease stage, ECOG performance status, HEC/MEC group, and whether patients had worked while on chemotherapy. **CONCLUSIONS:** The study identifies substantial group differences in preference and WTP that could be incorporated into the management of CINV.

Cancer – Health Care Use & Policy Studies

PCN97

IMPACT OF GLOBAL HEALTH CARE REFORMS ON PRICING, ACCESS AND HEALTH ECONOMICS AND OUTCOMES STRATEGY

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OBJECTIVES: During 2009-2010 major healthcare reforms were proposed and implemented in a number of nations, for example, Affordable Care Act in the US, AMNOG in Germany, HSPT in France, KVG in Switzerland and NHS proposed reform in the UK. These reforms have major implications on pricing, market access and HEOR strategy for drug and device products. **METHODS:** To understand the implications of these trends, we analyzed 2009-2010 reform bills and proposed changes worldwide. Additionally, we interviewed public and private payers, key opinion leaders and payer-influencers to understand implications of these reforms on drug and device manufacturers. **RESULTS:** The global healthcare landscape is expected to undergo significant change during 2011-2015. In the US, government will play increased role as a single payer, especially with–Medicare, Medicaid and CHIP programs– which will cover 114 million Americans, at a cost of $784 billion. In Germany, AMNOG bill marked the end of free drug pricing and would lead to increased insurance premiums (now 15.5% of wages). In the UK, NHS has proposed to replace PCTs with 500-1000 GP-led consortia and use value-based pricing for expensive drugs and devices. Overall, payers view that in the future, health economic assessments would play critical role in pricing, coverage and reimbursement of branded products. **CONCLUSIONS:** This analysis shows that global healthcare landscape is expected to undergo significant change during 2011-2015. Discussions with payers, KOLs and payer-influencers highlights increased importance of HEOR data in the future.

PCN99

ITALIAN MONITORING REGISTRY OF BEVACIZUMAB IN THE TREATMENT OF METASTATIC COLON RECTAL CARCINOMA

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OBJECTIVES: The treatment of bevacizumab in patients with metastatic colorectal carcinoma, in combination with fluoropyrimidine-based chemotherapy, is purchased by the NHS according to an agreement issued between AIFA and the manufacturer. The agreement includes the enrollement of patient in a monitoring registry and a cost-sharing scheme, based on 50% discounts of initial therapy cycles for all eligible patients and the refund of cost of doses exceeding the total dosage of 11.000 mg for each year of treatment (capping-dosage). This study is aimed at the economic evaluation of the financial agreement on the basis of evidences collected by the Registry. **METHODS:** Data were collected for patients enrolled in 2009, lock-on database at November 30, 2010. Data on baseline characteristics were analysed for eligible patients, whereas duration treatment, dosage and financial outcome were collected for patients whose therapy was completed. **RESULTS:** The Registry enrolled 4602 patients. Baseline patient age included 52.8% patients aged < 65 years, 24.4% of patients with an ECOG performance status ≥1. At database lock, 2667 (57.9%) patients had completed the treatment, 66.3% for progression disease, 2.8% patients had died, 13.3% for clinical decision and 4.7% for the medicine toxicity, 13.3% for non-related medicine causes. The dosage of 5-mg/kg every two-weeks was the most used, both in first (84.5%) and in second-line (81.9%). Median-duration therapy was 160-day (9 cycles). Data on safety were consistent with available evidences. The cost-sharing-agreement financial outcome produced was a median discount of 12.2% of therapy costs reimbursed by NHS: cost-sharing accounting for 12.1% and capping-dosage for 0.1%. **CONCLUSIONS:** The implementation of the cost-sharing scheme supported early patient access to the treatment, introducing bevacizumab in Italy at global-reference-price, with an effective overall discount produced essentially by the cost-sharing tool, linked to dosage and number of total doses required. The Registry also facilitated the collection of utilization evidences from real clinical world, improving the appropriate use and increasing efficiency.

PCN100

RACIAL DISPARITIES IN AFRICAN AMERICAN VERSUS WHITE WOMEN WITH NEWLY DIAGNOSED BREAST CANCER IN A SOUTHEAST UNITED STATES HEALTH PLAN

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OBJECTIVES: Identify differences in diagnosis and treatment of commercially insured White and African American women with newly diagnosed breast cancer. **METHODS:** We conducted a retrospective, observational analysis of a Southeast US health plan's administrative claims data linked to Georgia Comprehensive Cancer Registry (GCCR) data from 1/1/04 to 12/31/07 on newly diagnosed African American and White breast cancer patients. Medical and pharmacy utilization data were obtained from the claims. Cancer characteristics such as diagnosis date, Estrogen/Progesterone Receptor (ER/PR) status and race were obtained from the GCCR. Patients without race data or coded as other races were removed for a final sample size of 1,497. Descriptive analyses were conducted with t-tests for continuous variables and chi-square for categorical variables. Multiple logistic regression determined factors associated with lower use of anti-estrogen therapy among African American women. **RESULTS:** When comparing African American to White women, African American women were younger at diagnosis (mean age: 50 vs. 53 years, p<0.01), were diagnosed at later stages of breast cancer (Stage 0: 20% vs. 21%; Stage 1: 30% vs. 38%; Stage 2: 30% vs. 27%; Stage 3: 10% vs. 7%; Stage 4: 5% vs. 1% and unknown stage: 6% vs. 5%, p<0.01), and had a longer time to treatment (surgery: 57 vs. 42 days, p=0.01; radiation: 177 vs. 138 days, p<0.01; anti-estrogen therapy: 211 vs. 180 days, p=0.07). Among women who were ER/PR-positive, White women were more than twice as likely as African American women to be treated with anti-estrogen therapy (OR = 2.24, 95% CI: 1.46-3.43), after controlling potential confounders. **CONCLUSIONS:** This study demonstrates that diagnosis and treatment of breast cancer in African American women differ from that of White women despite having access to commercial insurance. We also illustrate that data linkages provide quick and efficient methods for assessment of cancer treatment patterns and identification of targets for further research.

PCN101

HEALTH CARE RESOURCE UTILIZATION AND ECONOMIC BURDEN OF METASTATIC AND RECURRENT LOCALLY-ADVANCED HEAD AND NECK CANCER PATIENTS

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OBJECTIVES: To assess healthcare resource utilization and economic burden associated with metastatic and recurrent, locally-advanced head and neck cancer (HNC). **METHODS:** Administrative claims from Medicare- and privately-insured